ERGONOMIC COMFORT SURVEY

Name: _____(Optional) Code:_____
Phone:_____ Building: _____ Room: _____
Job Title: _____

Circle the number on a scale of 0 - 10 to describe your level of discomfort.

No Discomfort At All = 0 Worst Imaginable Discomfort = 10

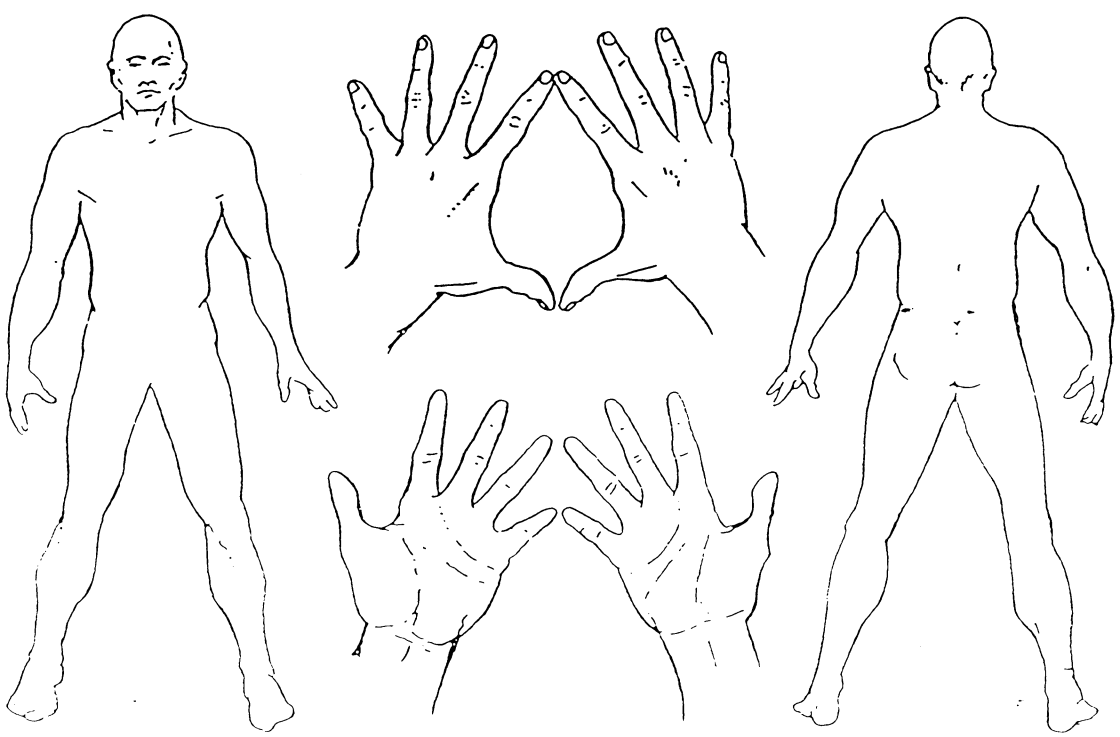
At your worst:
0--------1---------2---------3--------4---------5---------6--------7--------8---------9----------10

At your best:
0--------1---------2---------3--------4---------5---------6--------7--------8---------9----------10

Currently:
0--------1---------2---------3--------4---------5---------6--------7--------8---------9----------10

Describe discomfort you are having in any part of your body.

A=Aching S=Stabing NT=Numb/Tingle P=Pain ST=Stiff
B=Burning SW=Swell O=Other



ERGONOMIC COMFORT SURVEY

Name: _____(Optional) Code:_____
Phone:_____ Building: _____ Room: _____
Job Title: _____

Indicate whether any of the following conditions create problems in your job?

	Never	Sometimes	Frequently	Constantly
Temperature	1	2	3	4
Drafts	1	2	3	4
Odors	1	2	3	4
Equipment noise	1	2	3	4
Distracting noise	1	2	3	4
Chair comfort	1	2	3	4
Backrest comfort	1	2	3	4
Workspace	1	2	3	4
Storage space	1	2	3	4
Legroom	1	2	3	4
Table height	1	2	3	4
Keyboard height	1	2	3	4
Place to rest arms	1	2	3	4
Amount of light	1	2	3	4
Glare from light	1	2	3	4
Glare from window	1	2	3	4
Reflections on desks	1	2	3	4
Reflections on VDT	1	2	3	4

Comments:_____
_____
_____

Indicate how often you have experienced each of the following listed below within the past six months.

	Never	Sometimes	Frequently	Constantly
Pain or stiffness in your arms	1	2	3	4
Pain or stiffiness in your neck	1	2	3	4
Pain or stiffness in your shoulders	1	2	3	4
Pain or stiffness in your back	1	2	3	4
Burning eyes	1	2	3	4
Eyestrain	1	2	3	4
Headaches	1	2	3	4
Leg cramps	1	2	3	4

Comments:_____
_____
_____